Application

Personal Care Services for Children

Instructions

1. *This application may be completed by a parent, guardian, physician, nurse, school official, or any other person working with the family. The application must be signed by the parent or guardian to show their involvement and agreement with the request.*

2. *Please return the completed application, assessment and care plan to:*

ATTN: Children's Personal Care Services
Division of Disability and Aging Services
103 South Main Street—Weeks Building
Waterbury, VT 05671-1601

please note that without the assessment and care plan, the application is not considered complete and cannot be processed

3. *Within ten to fifteen business days of receipt of the assessment, DAIL will mail a notice to the parent or guardian telling them if the child is medically eligible for children's personal care services.*

Child's Name _____ Medicaid ID _____

Address _____ Date of birth _____

_____ Telephone _____

Parent or guardian _____ Telephone, if different _____

Address, if different _____

_____

Child's primary physician _____ Telephone _____

Address _____

*Medicaid Provider to Conduct Assessment:
Name_____ Telephone_____
Address_____

Name of person making referral_____

Reason for Personal Care Services application:

_____

_____

Signature of parent or guardian _____ Date _____